

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIBRA HOSPITAL OF NORTHWESTERN INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9509 GEORGIA ST CROWN POINT, IN 46307</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00159143 Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 5/13/15</p> <p>Facility Number: 012131</p> <p>Vibra Hospital of Northwestern Indiana is in compliance with 410 IAC 15-1.5-1, Dietetic service and 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 06/09/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE